

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02924

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |   |   |  |  |  |   |                                   |
|---|--|---|---|---|--|--|--|---|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br><b>Mary</b>  | Middle<br><b>Evelyn</b>   | Lost<br><b>Ammons</b>  | 2a. DATE OF DEATH<br>Month<br><b>Feb.</b>                    | Year<br><b>1969</b>  | 2b. HOUR<br>M.  |                                   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cau.</b>  | 5. DATE OF BIRTH<br><b>July 14, 1912</b>  |   |  | 6. AGE (In years<br>last birthday)<br><b>56</b> YRS.         |  |   |                                   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br><b>St. Marys</b>                       |  |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Charlotte Hall</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>N/A</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housework</b> |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Domestic</b>                 |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>St. Marys</b>   | 13c. CITY OR TOWN<br><b>Charlotte Hall</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>None</b>                        |  |   |                                   |
| 14. FATHER'S NAME<br>First<br><b>C. C.</b>  |  | Middle<br><b>Clemens</b>  | Lost  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Lilly</b>   |  | Middle<br><b>Maude</b>                                       | Lost<br><b>Moore</b>   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>231-22-2466</b>  |   | 17. INFORMANT<br><b>Weslie Ammons, Charlotte Hall, Md.</b>                                      |  | Address  |  |   |                                   |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Obstruction</i><br/> <i>150 X</i><br/> <i>150</i><br/> <i>Conditions, if any, which gave<br/>rise to immediate cause (a),<br/>stating the underlying cause</i><br/> <i>lost.</i><br/> <i>150 X</i><br/> <i>DUE TO, OR AS A CONSEQUENCE OF</i><br/> <i>(b)</i><br/> <i>DUE TO, OR AS A CONSEQUENCE OF</i><br/> <i>(c)</i><br/> <i>Ca g Oesophagus</i><br/> <i>5 yrs</i></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> |  |   |   |   |  |  |  |   |                                   |
| 19a. MEDICAL CERTIFICATION  |  | 19b. DATE OF OPERATION  |   |   | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>Month</b> Day <b>Year</b><br>P.M. <b>19</b>               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |  |  |  |   |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)               |   | 21f. LOCATION<br>Street or R.F.D. No.   | City or Town   |  | County   | State   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1957</b> , to <b>Feb 1969</b> , that (I) (we) last<br>saw the deceased alive on <b>Aug 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |   | 22c. DATE SIGNED<br><b>3/1/69</b> |
| 22b. SIGNATURE<br><i>Mossman</i>  |  | DEGREE  | ATTENDING<br>PHYS.  | <input checked="" type="checkbox"/> MED.<br>DIRECTOR  |  | STAFF<br>PHYS. <input type="checkbox"/>                      |  |   |                                   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>David L. Mossman M.D.</b>   |  | 22e. ADDRESS<br><b>Mechanicsville, Md. 20659</b>  |   |   |  |  |  |   |                                   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-2-69</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Cedarville Cemetery</b>  |   |  | 23d. LOCATION (City or Town)<br><b>Cedarville, P.G., Md.</b> |  | (County)  | (State)                           |
| 24. FUNERAL DIRECTOR  |  | ADDRESS<br><b>Huntt Funeral Home, Waldorf, Md.</b>  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 3 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                   |   |                                   |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

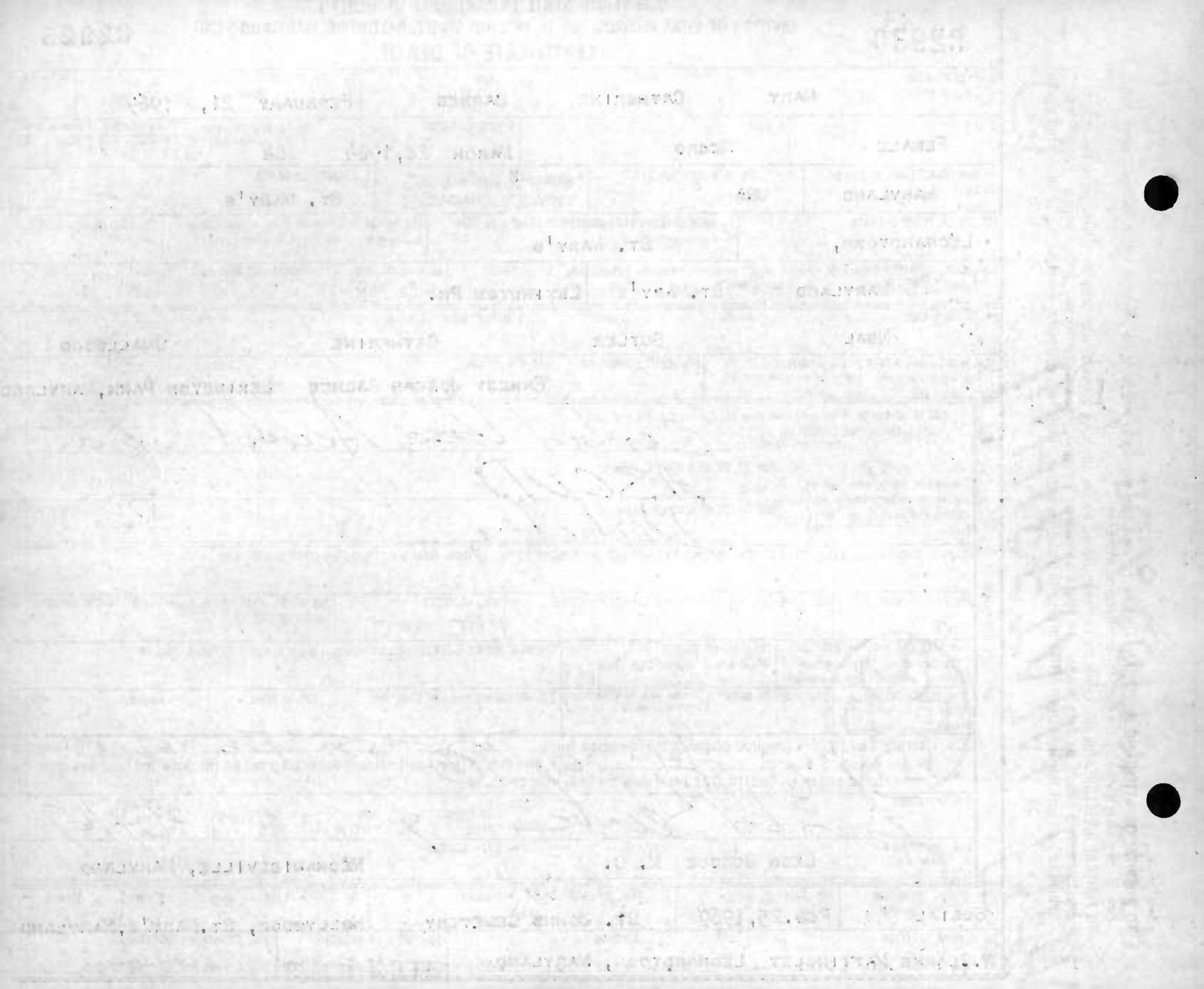
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02930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |   |   |   |                                   |
|--|--|--|---|---|---|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  | First<br><b>MARY</b>   | Middle<br><b>CATHERINE</b>   | Last<br><b>BARNES</b>   | 2a. DATE OF DEATH<br><b>FEBRUARY 21, 1969</b>   | 2b. HOUR<br>M   |                                   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br><b>MARCH 28, 1904</b>  |   | 6. AGE (In years<br>last birthday)<br><b>64</b>   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                       | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH<br><b>ST. MARY'S</b>   |   |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>LEONARDTOWN,</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>ST. MARY'S</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)                    |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>ST. MARY'S</b>   | 13c. CITY OR TOWN<br><b>LEXINGTON Pk.</b>  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>SMALLWOOD</b>  |   |                                   |
| 14. FATHER'S NAME<br>First<br><b>NEAL</b>  | Middle<br><b>BUTLER</b>  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>CATHERINE</b>  |   |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>Yes</b>  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                    | 17. INFORMANT<br><b>ERNEST JOSEPH BARNES</b>   | Address<br><b>LEXINGTON PARK, MARYLAND</b>  |   |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |   |   |                                   |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Vase Accident</i> APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6d.</b>  |  |  |   |   |   |                                   |
| 2509<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the <u>underlying cause</u><br><b>lost.</b>  |  |  |   |   |   |                                   |
| (b) <i>Arteriosclerosis</i>  |  |  |   |   |   |                                   |
| (c) <i>Diabetes</i>  |  |  |   |   |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>19</b> P.M.  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>19</b>                  |   |   |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  | 21f. LOCATION Street or R.F.D. No.<br>City or Town<br>County<br>State   |   |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/21/69</b> to <b>Feb 19, 1969</b> , that (II) (we) last<br>saw the deceased alive on <b>2/21/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |                                   |
| 22b. SIGNATURE<br><i>Leon B. Burbue</i>  |  | DEGREE<br>ATTENDING<br>PHYS.   | <input checked="" type="checkbox"/> MED.<br>DIRECTOR  | <input type="checkbox"/> STAFF<br>PHYS.   | 22c. DATE SIGNED<br><b>2/24/69</b>                                      |                                   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>LEON BURBUE M. D.</b>  |  | 22e. ADDRESS<br><b>MECHANICSBVILLE, MARYLAND</b>   |   |   |   |                                   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>FEB. 25, 1969</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>ST. JOHNS CEMETERY</b>   | 23d. LOCATION (City or Town)<br><b>HOLLYWOOD, ST. MARY'S, MARYLAND</b>                  | (County)  | (State)                           |
| 24. FUNERAL DIRECTOR<br><b>W. CLARKE MATTINGLEY</b>  |  | ADDRESS<br><b>LEONARDTOWN, MARYLAND</b>  | 25a. REC'D BY REGISTRAR<br><b>DE</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Yeraga</i>                                     |   |                                   |



02931

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

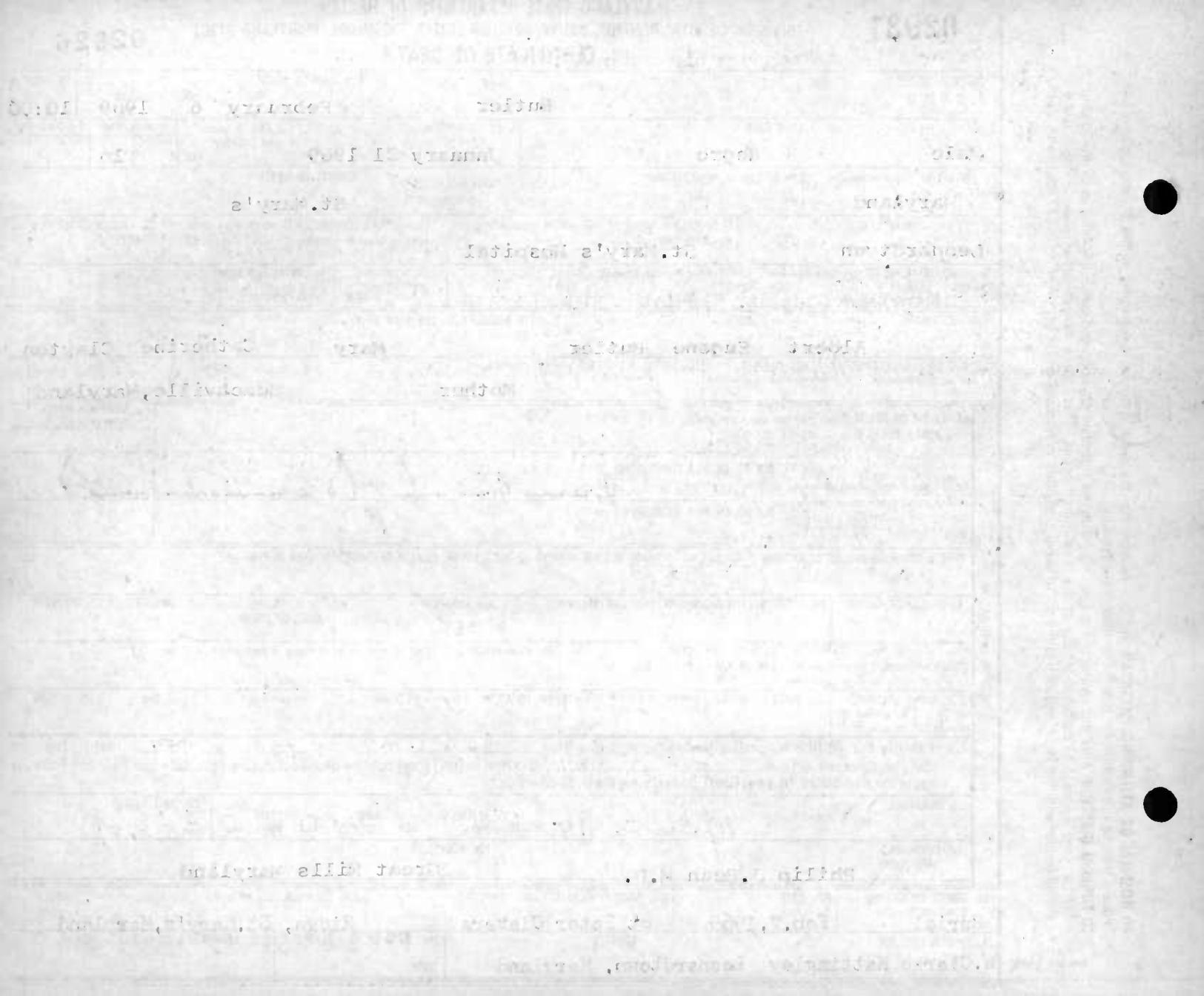
02926

Information taken from birth cert. CERTIFICATE OF DEATH

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|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print)   | First  | Middle  | Lost   | 2a. DATE OF DEATH<br>Month  | 2b. HOUR A<br>Year  |
|   |  |   | Butler   | February 6  | 10:00   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                |
| Male  | Negro  | January 21 1969   |  | — yrs.  | 16  |
| 7a. BIRTHPLACE (State or foreign<br>country)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>St. Mary's   |   |   |
| Maryland  | USA  |   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Leonardtown  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Mary's Hospital |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |
| Maryland  | 13a. USUAL RESIDENCE (Where deceased<br>lived, if institution: Residence before<br>admission) STATE    | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br>General Delivery                              |
|   | St. Mary's   |   | Beachville   |   |   |
| 14. FATHER'S NAME   | First  | Middle  | Lost   | 15. MOTHER'S MAIDEN NAME  | First   |
| Albert Eugene Butler  |  |   |  | Mary  | Catherine Clayton   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT   | Address<br>Beachville, Maryland  |   |   |
|   |  | Mother  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |   |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |   |   |
| IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause _____<br>lost. _____<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Pruritis infant (5 1/2 months development)                              |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)  |  |   |  |   |   |
| 19a. MEDICAL CERTIFICATION  |  | 19b. DATE OF OPERATION  | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |
|   |  |   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   | 21f. LOCATION Street or R.F.D. No.   | City or Town  | County State  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 21, 1969, to Feb 6, 1969, that (I) (we) last<br>saw the deceased alive on Feb 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br>Philip J. Bean M.D.   |  |   |  |   |   |
| 22c. DATE SIGNED<br>Feb 6/69  |  |   |  |   |   |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  | 22e. ADDRESS<br>Great Mills Maryland  |  |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>Feb. 7, 1969   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>St Peter Clavers                                   | 23d. LOCATION (City or Town)<br>Ridge, St. Mary's, Maryland                                     | (County) (State)  |
| 24. FUNERAL DIRECTOR<br>W. Clarke Mattingley  |  | ADDRESS<br>Leonardtown, Maryland  | 25a. FEE BY REGISTRAR<br>FEB 11 1969   | 25b. REGISTRAR'S SIGNATURE<br>judge   |   |
| 30M REV. 1/68   |  |   | DATE   |   |   |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02927

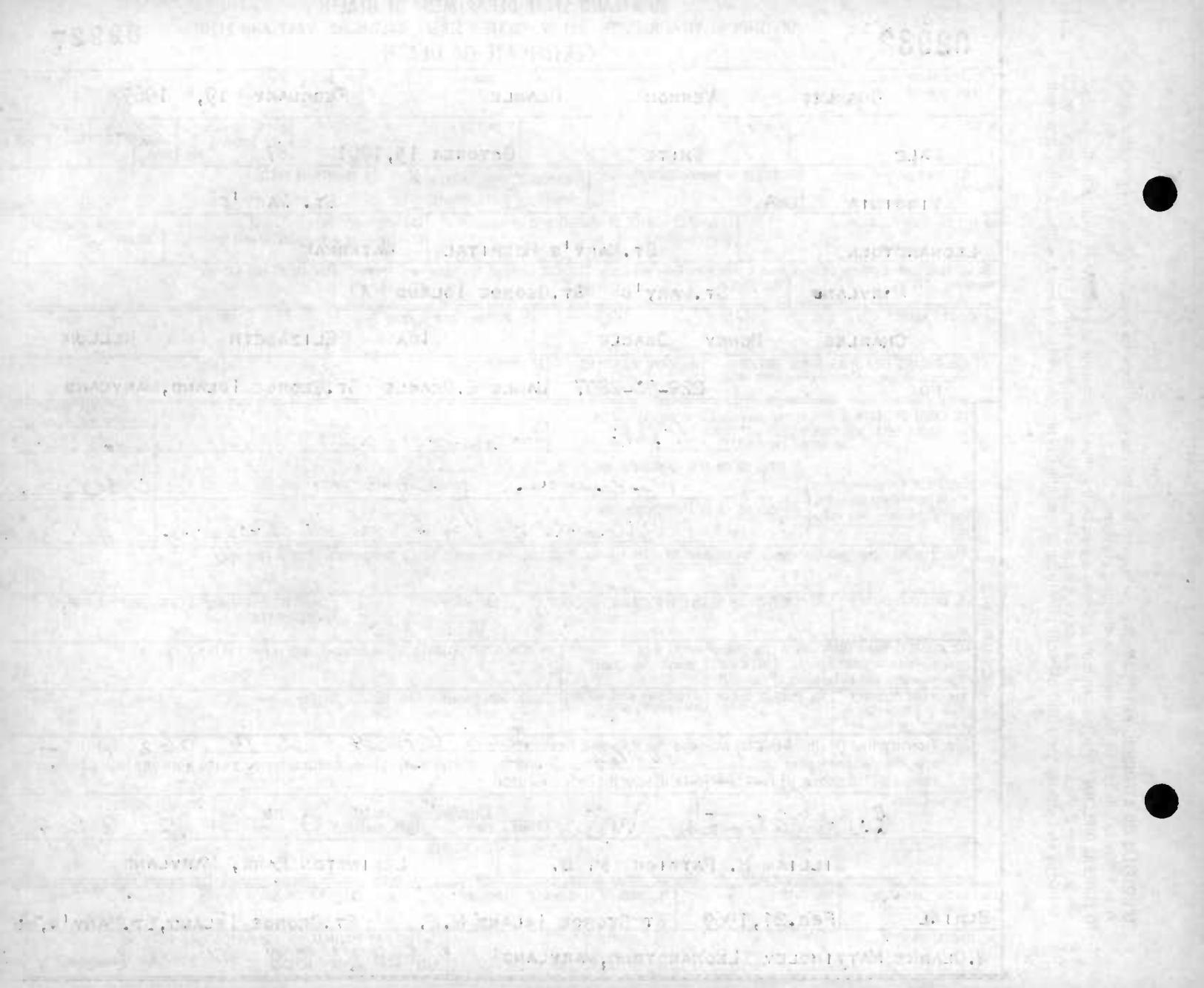
02932

## CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

|   |   |  |   |  |   |                       |         |
|---|---|--|---|--|---|-----------------------|---------|
| 1. DECEASED-NAME<br>(Type or print)   | First<br><b>CHARLES</b>   | Middle<br><b>VERNON</b>  | Lost<br><b>DEAGLE</b>   | 2a. DATE OF DEATH<br><b>FEBRUARY 19, 1969</b>  | 2b. HOUR<br>M   |                       |         |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br><b>OCTOBER 15, 1901</b>  |   | 6. AGE (In years<br>last birthday)<br><b>67</b>                                      | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN                       |                       |         |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b> VIRGINIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b> USA</b>   | 8. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH<br><b>ST. MARY'S</b>   |  |   |                       |         |
| 10. CITY OR TOWN OF DEATH<br><b>LEONARDTOWN, MD</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>ST. MARY'S HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>WATERMAN</b> |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |                       |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>ST. MARY'S</b>  | 13c. CITY OR TOWN<br><b>ST. GEORGE ISLAND, MD</b>  | 13d. INSIDE CITY LIMITS?<br><b>NO</b>   | 13e. STREET AND NUMBER   |   |                       |         |
| 14. FATHER'S NAME<br><b>CHARLES</b>   | First<br><b>CHARLES</b>   | Middle<br><b>HENRY</b>   | Lost<br><b>DEAGLE</b>   | 15. MOTHER'S MAIDEN NAME<br><b>IDA</b>   | Middle<br><b>ELIZABETH</b>  | Last<br><b>KELLUM</b> |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br><b>NO</b>   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>220-38-2807</b>                       | 17. INFORMANT<br><b>JAMES E. DEAGLE</b>  |   | Address<br><b>ST. GEORGE ISLAND, MARYLAND</b>  |   |                       |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>493 X</b> <i>lobar pneumonia</i>   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 weeks</b>                    |   |                       |         |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br><b>Chronic bronchial asthma</b>   |   |  |   |  |   |                       |         |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br><b>Pulmonary Fibrosis</b>  |   |  |   | 10 days  |   |                       |         |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br><b>Chronic Bronchial Asthma</b>  |   |  |   | 25 days  |   |                       |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |  |   |  |   |                       |         |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                       |         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |                       |         |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |   | 21f. LOCATION<br>Street or R.F.D. No.  | City or Town  | County                | State   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-6-69</b> to <b>2-19-69</b> , that (I) (we) last<br>saw the deceased alive on <b>2-19-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |  |   |                       |         |
| 22b. SIGNATURE<br><i>W.H. Patrick M.D.</i>  |   | DEGREE<br><b>W.H. PATRICK M.D.</b>   | ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/> MED.<br>DIRECTOR                                    | STAFF<br>PHYS.<br><input type="checkbox"/>   | 22c. DATE SIGNED<br><b>2-19-69</b>                                      |                       |         |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>WILLIAM H. PATRICK M.D.</b>   |   | 22e. ADDRESS<br><b>LEXINGTON PARK, MARYLAND</b>  |   |  |   |                       |         |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>FEB. 21, 1969</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>ST. GEORGE ISLAND M.E.</b>   | 23d. LOCATION (City or Town)<br><b>ST. GEORGE ISLAND, ST. MARY'S, MD</b>             |   | (County)              | (State) |
| 24. FUNERAL DIRECTOR<br><b>W. CLARKE MATTINGLEY</b>   |   | ADDRESS<br><b>LEONARDTOWN, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR<br><b>FEB 24 1969</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>W. Clarke M. George</i>                |                       |         |



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

02928

Information taken from birth certificate

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, director, page 3 should be detached for use as the burial-transit permit. Please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |   |   |   |              |  |                          |                           |       |         |
|---|--|---|---|---|---|--------------|--|--------------------------|---------------------------|-------|---------|
| 1. DECEASED NAME<br>(Type or print)   | First  | Middle  | Lost  | 2a. DATE OF DEATH<br>Month  | Day   | Year         | 2b. HOUR   |                          |                           |       |         |
| Jerry   |  | Michael   | EIS   | February  | 7   | 1969         | 0220AM   |                          |                           |       |         |
| 3. SEX  | 4. RACE  |   | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)                                     |              | IF UNDER 1 YEAR<br>MONTHS  | IF UNDER 24 HRS.<br>DAYS | IF UNDER 24 HRS.<br>HOURS | MIN   |         |
| Male  | Caucasian  |   | 4 February 1969   |   | YRS.  |              | 0  | 3                        |                           |       |         |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |              |  |                          |                           |       |         |
| Maryland  | U.S.   |   |   |   | St. Mary's  |              |  |                          |                           |       |         |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |              | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                          |                           |       |         |
| Lexington Park  | Naval Hospital   |   |   |   |   |              |  |                          |                           |       |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   | 13b. CITY OR TOWN  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |              | 13e. STREET AND NUMBER   |                          |                           |       |         |
| Maryland  | St. Mary's   |   | Lex. Park   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |              | Rt. 4, Box 432-201   |                          |                           |       |         |
| 14. FATHER'S NAME   | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  | First   | Middle       | Last   |                          |                           |       |         |
| Jerrold   | Lewis  | EIS   |   | Alice   | Jean  | Kaufman      |  |                          |                           |       |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   | Address   |              |  |                          |                           |       |         |
| No  | (If yes give war or dates of service)  |   | Medical Records - Father TrailerPk, LexPkMd   |   | Lot #68 Hills   |              |  |                          |                           |       |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   |   |              |  |                          |                           |       |         |
| PART I. DEATH WAS CAUSED BY:  |  |   |   |   |   |              |  |                          |                           |       |         |
| IMMEDIATE CAUSE (a) Respiratory Distress  |  |   |   |   |   |              |  |                          |                           |       |         |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |   |              |  |                          |                           |       |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Brain Damage   |  |   |   |   |   |              |  |                          |                           |       |         |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |   |              |  |                          |                           |       |         |
| (c) Cerebral Dysfunction  |  |   |   |   |   |              |  |                          |                           |       |         |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |   |   |   |              |  |                          |                           |       |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |   |              |  |                          |                           |       |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?   |              | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                          |                           |       |         |
|   |  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |              |  |                          |                           |       |         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |              |  |                          |                           |       |         |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town |  | County                   |                           | State |         |
| 22a. I certify that (I) (This hospital) attended the deceased from 7 FEB 1969, to 7 FEB 1969, that (I) (He) last saw the deceased alive on 7 FEB 1969, and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (He) (did) (did not) view the body after death. |  |   |   |   |   |              |  |                          |                           |       |         |
| 22b. SIGNATURE  |  |   |   |   |   |              |  |                          |                           |       |         |
| D. C. PETRINIO, LT MC USNR  |  |   |   |   |   |              |  |                          |                           |       |         |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS  |   |   | 22c. DATE SIGNED  |              |  |                          |                           |       |         |
| D. C. PETRINIO, LT MC USNR  |  | Naval Hospital, Patuxent River, Maryland  |   |   | 7 FEB 1969  |              |  |                          |                           |       |         |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>TRANSIT   |  | 23b. DATE<br>2/9/69   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>ADDRESS   |   |              | 23d. LOCATION (City or Town)<br>BELLINGHAM, WASH.                    |                          | (County)                  |       | (State) |
| 24. FUNERAL DIRECTOR<br>JOHN M. WELCH   |  | ADDRESS<br>JOHN M. WELCH - LEONARDTOWN, MD.                                     |   |   | 25a. REC'D BY REGISTRAR<br>FEB 11 1969                              |              | 25b. REGISTRAR'S SIGNATURE<br>W. Charles Jones                       |                          |                           |       |         |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02929

02934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |   |   |   |   |                      |
|--|--|---|---|---|---|---|---|----------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>JAMES</b>   | Middle<br><b>FRANCIS</b>  | Lost<br><b>GARNER, SR.</b>  | 2a. DATE OF DEATH<br>Month<br><b>FEB.</b>                               | Doy<br><b>22.</b>                                       | Year<br><b>1969</b>                               | 2b. HOUR<br><b>M</b> |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br><b>AUGUST 17, 1914</b>  |   | 6. AGE (In years<br>lost birthday)<br><b>54</b> YRS.                    |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN |                      |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>WASHINGTON, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>ST. MARY'S COUNTY</b>                          |   |   |                      |
| 10. CITY OR TOWN OF DEATH<br><b>LEONARDTOWN, MD.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>ST. MARY'S HOSPITAL</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>MERCHANT - RETIRED</b> |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>MERCHANT</b> |   |                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission)<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>ST. MARY'S</b>  | 13c. CITY OR TOWN<br><b>TALL TIMBER</b>   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>           | 13e. STREET AND NUMBER  |   |   |                      |
| 14. FATHER'S NAME<br><b>CHARLES</b> J. <b>GARNER</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>JENNIE</b>   |   |   |   |   |   |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-01-5649</b>  | 17. INFORMANT<br><b>JAMES F. GARNER, JR.</b>  |   | Address<br><b>TALL TIMBER, MD.</b>                                      |   |   |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | 1531<br><b>Heart failure</b>  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                      |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause   |  | DUE TO, OR AS A CONSEQUENCE OF<br><b>Congestive heart failure</b>   |   |   |   |   |   |                      |
|  |  | (b) <b>Congestive heart failure</b>   |   |   |   |   |   |                      |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br><b>Congestive heart failure</b>   |   |   |   |   |   |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (GIVEN IN PART 1(a))   |  | <b>Stokes-Adams syndrome</b>  |   |   |   |   |   |                      |
| 19a. MEDICAL CERTIFICATION<br>DATE OF OPERATION<br><b>2-13-69</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Vulvostinal obstruction</b>                            |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |   |                      |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |                      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               | 21f. LOCATION Street or R.F.D. No.  | City or Town  | County  | State   |   |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-11-69</b> , 19 <b>69</b> , to <b>2-22-69</b> , 19 <b>69</b> , that (I) (we) last<br>saw the deceased alive on <b>2-22-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |   |   |                      |
| 22b. SIGNATURE<br><b>A. Samadi</b>   |  | 22c. DEGREE<br><b>M.D.</b>  | ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/>   | MED.<br>DIRECTOR<br><input type="checkbox"/>  | STAFF<br>PHYS.<br><input type="checkbox"/>                              | 22d. DATE SIGNED<br><b>2-24-69</b>                      |   |                      |
| 22e. ADDRESS<br><b>LEONARDTOWN, MARYLAND</b>   |  |   |   |   |   |   |   |                      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>FEB. 25, 1969</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>ST. GEORGE'S CEMETERY</b>  | 23d. LOCATION (City or Town)<br><b>VALLEY LEE</b>   | (County)<br><b>ST. MARY'S, MD.</b>                                      | (State)   |   |                      |
| 24. FUNERAL DIRECTOR<br><b>John M. Welch</b>   |  | ADDRESS<br><b>LEONARDTOWN, MD.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>FEB 26 1969</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>John M. Welch</b>                      |   |   |                      |
| VR A15 (4)<br>30M REV. 1/68  |  |   |   |   |   |   |   |                      |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02935

02930

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death.  
Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |  |   |  |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(Type or print)  | First<br>John  | Middle<br>Marshall  | Last<br>Gragan  | 20. DATE OF DEATH<br>Month<br>February   | Day<br>7, 1969  | 2b. HOUR   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>March 22, 1902  |   |  | 6. AGE (In years<br>and birthday)<br>66                                 | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED   | 9. COUNTY OF DEATH<br>St. Mary's  | 10. CITY OR TOWN OF DEATH<br>Leonardtown   |   |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Mary's Hospital   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Farming |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   | 13b. COUNTY<br>St. Mary's  | 13c. CITY OR TOWN<br>Colton Point   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br>Colton Point   |   |  |
| 14. FATHER'S NAME<br>First<br>William  | Middle<br>Edward   | Last<br>Gragan  | 15. MOTHER'S MAIDEN NAME<br>Josephine   | First<br>Anna  | Middle<br>Quade   | Last   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>214-32-9511 | 17. INFORMANT<br>Virgie L. Gragan   | Address<br>Colton Point, Maryland   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Coronary Thrombosis<br>Coronary Artery Disease |  |   |   |  |   |  |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>min.<br>41.   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                    | 21f. LOCATION<br>Street or R.F.D. No.   | City or Town   | County  | State  |
| 22a. I certify that (I) (his hospital) attended the deceased from<br>saw the deceased alive on <u>Jan 20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>James P. Jarboe M. D.</u>   |  | DEGREE<br>ATTENDING<br>PHYS.  | <input checked="" type="checkbox"/> M.D.<br>DIRECTOR  | <input type="checkbox"/> STAFF<br>PHYS.  | 22c. DATE SIGNED<br><u>2/2/69</u>                                       |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>James P. Jarboe M. D.   |  | 22e. ADDRESS<br>Great Mills, Maryland   |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Feb. 10, 1969  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Sacred Heart  | 23d. LOCATION (City or Town)<br>(County) (State)<br>Bushwood, St. Mary's, Maryland |   |  |
| 24. FUNERAL DIRECTOR<br>W. Clarke Mattingley   |  |   | ADDRESS<br>Leonardtown, Maryland  | 25a. REC'D. BY REGISTRAR<br>FEB 11 1969  | 25b. REGISTRAR'S SIGNATURE<br><u>W. Clarke Mattingley</u>               |  |



FOR STATE  
HEALTH DEPT.

Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page  
5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02931

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                                     |   |   |  |  |                   |              |  |                 |
|---|-------------------------------------|---|---|--|--|-------------------|--------------|--|-----------------|
| 1. DECEASED-NAME<br>(Type or Print)   |                                     | First<br>W.   | Middle<br>B.  | Lost<br>HICKS JR.  | 2d. DATE<br>OF ESTI-<br>DEATH MATED<br><input checked="" type="checkbox"/> FEB. 9 1969                           | Month<br>11:00 PM | Day          | Year   | 2b. HOUR<br>Md. |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE                    | 5. DATE OF BIRTH<br>4/22/1932   | 6. AGE (in years<br>last birthday)<br>36 yrs.               | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS<br>DAYS<br>HOURS<br>MIN   | 2c. DATE PRONOUNCED DEAD<br>Month<br>FEB.  | Day<br>10         | Year<br>1969 | 2d. HOUR<br>7:00P  |                 |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>TEXAS   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>ST. MARYS                             |  |  |                   |              |  |                 |
| 10. CITY OR TOWN OF DEATH<br>POTOMAC RIVER  |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>EXECUTIVE SECRETARY |                   |              | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>LIBERTY LOBBY      |                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>WASHINGTON, D.C.)   |                                     | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              | 13e. STREET AND NUMBER<br>220 2ND ST. S.E.   |                   |              |  |                 |
| 14. FATHER'S NAME<br>W.   |                                     | Middle<br>B.  | Lost<br>HICKS SR.   | 15. MOTHER'S MAIDEN NAME<br>UNKNOWN  |  |                   |              |  |                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES   |                                     | 16b. SOCIAL SECURITY NO.<br>WWII  |   | 17. INFORMANT<br>RAYMOND J. WALKER JR.   | 67 ADDRESS<br>MAIN ST.<br>MEADEVILLE, PA.  |                   |              | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>15 MIN. |                 |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>HYPOTHERMIA</u><br/>901X<br/>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave<br/>rise to immediate cause (a),<br/>stating the underlying cause<br/>lost. (b)<br/>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>  |                                     |   |   |  |  |                   |              |  |                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                                     |   |   |  |  |                   |              |  |                 |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |   |  | 20. AUTOPSY?   |                   |              |  |                 |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                                     | 21b. TIME OF INJURY Month, Day, Year<br>11:00 P.M. 2/9 1969   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)<br>BOAT RAN AGROUND IN STORM |  |                   |              |  |                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK  |                                     | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>POTOMAC RIVER  |   | 21f. LOCATION Street or R.F.D. No.<br>MOUTH OF YEOCOMICO RIVER, ST. MARYS                                    |  | City or Town      | County       | State<br>MD.   |                 |
| <p>22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion<br/>death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL<br/>SIGNATURE <u>W.M. Boyd</u></p> <p>EXAMINER'S<br/>NAME (Type)<br/>WM. D. BOYD, M.D.</p> |                                     |   |   |  |  |                   |              |  |                 |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |                                     | 23b. DATE<br>2.14.69  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Culpepper, National | 23d. LOCATION (City or Town)<br>Culpepper, Virginia  | (County)   | (State)           |              |  |                 |
| 24. FUNERAL DIRECTOR<br>JOHN M. WELCH   |                                     | ADDRESS<br>JOHN M. WELCH - LEONARDTOWN, MD.   | 25a. REC'D BY REGISTRAR<br>FEB 14 1969                      | 25b. REGISTRAR'S SIGNATURE<br><u>John M. Welch</u>   |  |                   |              |  |                 |



02937

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 Film G409 2/20/69 kk

## CERTIFICATE OF DEATH

02932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that ~~herein~~ certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |   |   |  |
|--|--|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print)  | First<br>Ida                                 | Middle<br>Maria   | Last<br>Norris  | 20. DATE OF DEATH<br>Month Day Year<br>February 14, 1969  | 2b. HOUR  |  |
| 3. SEX<br>Female   | 4. RACE<br>White                             | 5. DATE OF BIRTH<br>Feb. 12, 1915   |   | 6. AGE (In years<br>last birthday)<br>54  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                       | IF UNDER 24 HRS.<br>HOURS<br>MIN                       |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>St. Mary's  |   | Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Leonardtown   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Mary's Hospital  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)      |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>St. Mary's   | 13c. CITY OR TOWN<br>Scotland   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER  |  |
| 14. FATHER'S NAME<br>Albert  | First<br>E.                                  | Middle<br>Greenwell   | Last  | 15. MOTHER'S MAIDEN NAME<br>Amy   | Middle<br>M.  | Last<br>Yateman  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  | 16b. SOCIAL SECURITY NO.<br>1530 213-38-2801 | 17. INFORMANT<br>Lloyd E. Norris  | Address<br>Scotland, Md.  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>hr. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>1530<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.            |  | Circulatory Collapse + Acidosis   |   | 4 mo.   |   |  |
| (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (b),<br>stating the underlying cause<br>last.   |  | Carcinomatosis  |   | 4 yrs.  |   |  |
| (c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (c),<br>stating the underlying cause<br>last.   |  | Adenocarcinoma of Cervix  |   | 4 yrs.  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |   |  |
| 19a. MEDICAL CERTIFICATION<br>DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   | 21f. LOCATION Street or R.F.D. No.  | City or Town  | County  | State  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1962 to 2/14, 1969, that (I) (we) last<br>saw the deceased alive on 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) did not view the body after death. |  |   |   |   |   |  |
| 22b. SIGNATURE<br>James P. Jarboe M. D.  |  | 22c. DATE SIGNED<br>2/14/69   | DEGREE<br>ATTENDING<br>PHYS.  | MED.<br>DIRECTOR  | STAFF<br>PHYS.  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS<br>Great Mills, Maryland   |   |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Feb 17, 1969   | 23c. NAME OF CEMETERY OR CREMATORIALY<br>Trinity Episcopal                      | 23d. LOCATION (City or Town)<br>St. Mary's City, St. M. Md.                                     | (County)  | (State)  |
| 24. FUNERAL DIRECTOR<br>W. Clarke Mattingley   |  | ADDRESS<br>Leonardtown, Md.   |   | 25a. REC'D BY REGISTRAR<br>FEB 17 1969  | 25b. REGISTRAR'S SIGNATURE<br>W. Clarke Mattingley                      |  |

3 ~~value & equal volume~~  
4 ~~not measured~~  
5 ~~good measurement~~

30/11/2019 - 01/12/2019 -  
Amritsar -

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMS - Page 5 may be retained for your files.

X

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

99  
18

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |  |  |  |   |  |                           |  |                          |  | 02933  |  |  |  |      |          |   |  |         |                  |  |  |  |
|---|---------|--|--|--|--|---|--|---------------------------|--|--------------------------|--|--|--|--|--|------|----------|---|--|---------|------------------|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |  |  |   |  |                           |  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 1. DECEASED NAME<br>(Type or Print)   |         |  | First  |  |  | Middle  |  |                           | Lost   |                          |  | 20. DATE KNOWN<br>DEATH MATED  |  | Month                                      | Day  | Year | 2b. HOUR |   |  |         |                  |  |  |  |
| GORDON  |         |  | Aug. 5, 1905   |  |  | PLUGGE  |  |                           |  |                          |  | <input checked="" type="checkbox"/>  |  | FEB. 26,                                   | 19   | 69   | M        |   |  |         |                  |  |  |  |
| 3. SEX  | 4. RACE | S. AGE OF DECEASED: Aug. 15, 1905<br>SEX: MALE |  |  | AGE (In years<br>at birthday)<br>AUGUST 15, 1905 / 61 yrs. |   |  | IF UNDER 1 YEAR<br>MONTHS |  | IF UNDER 24 HRS.<br>DAYS |  | MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Doy Year |  |      | 2d. HOUR |   |  |         |                  |  |  |  |
| MALE  |         |  | WHITE  |  |  |   |  |                           |  |                          |  |  |  |  | FEBRUARY 26, 19 69                                       |      |          |   |  |         |                  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |                           | 9. COUNTY OF DEATH   |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| WASHINGTON, DC  |         |  | USA  |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  |                           | ST. MARY'S   |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                           | 12b. KIND OF BUSINESS OR INDUSTRY  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| LEONARDTOWN   |         |  | D.O.A.   |  |  | ST. MARY'S HOSPITAL   |  |                           | POTOMAC ELECTRIC POWER Co.   |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |  |  | 13c. SANDGATES  |  |                           | 13d. INSIDE CITY LIMITS?   |                          |  | 13e. STREET AND NUMBER   |  |  |  |      |          |   |  |         |                  |  |  |  |
| MARYLAND  |         |  | ST. MARY'S   |  |  | MECHANICSVILLE  |  |                           | <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 14. FATHER'S NAME   |         |  | First  |  |  | Middle  |  |                           | 15. MOTHER'S MAIDEN NAME   |                          |  | First  |  |  | Middle   |      |          | Lost  |  |         |                  |  |  |  |
| AUGUST  |         |  | HENRY  |  |  | PLUGGE  |  |                           | DALAS  |                          |  | MARIE  |  |  | CAMPBELL   |      |          |   |  |         |                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)            |  |  | 17. INFORMANT   |  |                           | ADDRESS  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
|   |         |  | 577-05-0840  |  |  | SUSAN CATHERINE PLUGGE  |  |                           | SANDGATES,<br>MECHANICSVILLE, Md.  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>5718</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Gastrointestinal hemorrhage</u><br>stating the underlying cause (c) <u>Portal cirrhosis</u>   |         |  |  |  |  |   |  |                           |  |                          |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 years</u>            |  |  |  |      |          |   |  |         |                  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |  |  |  |   |  |                           |  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 19a. MEDICAL CERTIFICATION  |         |  | 19b. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |  |                           | 20. AUTOPSY?   |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
|   |         |  |  |  |  |   |  |                           | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |  | 21b. TIME OF INJURY Month, Doy, Year<br>HOUR A.M. P.M. 19                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |                           | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |                          |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  | 21f. LOCATION Street or R.F.D. No.                       |      |          | City or Town  |  | County  | State            |  |  |  |
|   |         |  |  |  |  |   |  |                           |  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |  |   |  |                           |  |                          |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |  |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> |      |          | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |         | 22b. DATE SIGNED |  |  |  |
| ACTUAL SIGNATURE <u>W.H. Boyd</u>   |         |  | EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.                                 |  |  |   |  |                           |  |                          |  |  |  |  |  |      |          | 22b. DATE SIGNED  |  | 2-26-69 |                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |         |  | 23b. DATE MARCH 1, 1969  |  |  | 23c. NAME OF CEMETERY OR CREMATORIUM EBENEZER CEMETERY                                  |  |                           | 23d. LOCATION (City or Town) CALIFORNIA  |                          |  | (County) ST. MARY'S, MARYLAND  |  |  |  |      |          |   |  |         |                  |  |  |  |
|   |         |  |  |  |  |   |  |                           |  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| 24. FUNERAL DIRECTOR  |         |  | ADDRESS  |  |  | 25a. REGD. BY REGISTRAR   |  |                           | 25b. REGISTRAR'S SIGNATURE   |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
| W. CLARKE MATTINGLEY  |         |  | LEONARDTOWN, MARYLAND  |  |  | MAR 5 1969  |  |                           |  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |
|   |         |  |  |  |  |   |  |                           |  |                          |  |  |  |  |  |      |          |   |  |         |                  |  |  |  |



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02934

02939

|  |  |  |   |  |   |   |   |
|--|--|--|---|--|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print)  | First<br>Carlton   | Middle<br>Lunza  | Lost<br>Robinson  | 20. DATE KNOWN<br>OF ESTI-<br>DEATH MATED<br>Feb. 4, 1969                                  | Month<br>Year<br>M                                  | 2b. HOUR<br>M   |   |
| 3. SEX<br>Male   | 4. RACE<br>Negro   | 5. DATE OF BIRTH<br>May 7, 1966  | 6. AGE (in years<br>last birthday)<br>2<br>YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>8   | IF UNDER 24 HRS.<br>DAYS<br>27                      | 2c. DATE PRONONCED DEAD<br>Month<br>Feb. 4<br>Year<br>1969  | 2d. HOUR<br>M   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED<br>WIDOWED<br>DIVORCED  | 9. COUNTY OF DEATH<br>St. Mary's  |  |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Piney Point   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)            |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                        |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   | 13b. COUNTY<br>St. Mary's  | 13c. CITY OR TOWN<br>Piney Point   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER   |   |   |   |
| 14. FATHER'S NAME<br>Rudolph   | First<br>J.  | Middle<br>Robinson   | Lost  | 15. MOTHER'S MAIDEN NAME<br>Gloria   | First<br>Ann  | Middle  | Lost<br>Thomas  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                          | 17. INFORMANT  | ADDRESS<br>Gloria Ann Robinson Piney Point, Maryland  |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>890X</i> Burns Extreme<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause (b) _____<br>last. _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>ended    |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |   |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                                       |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |   |   |   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR AM 1:00 P.M. 2-4 1969                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>old stone exploded - causing house fire |   |  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>at home | 21f. LOCATION Street or R.F.D. No.<br>Piney Point  | City or Town<br>St. Mary's  | County<br>Md   | State<br>Md   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |  |   |   |   |
| ACTUAL<br>SIGNATURE<br><i>Alma D. Boyd</i>   | 22b. DATE SIGNED<br>2-5-69   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | ADDRESS (Street, city, town, or county)<br>Bushwood, St. Mary's, Maryland |
| EXAMINER'S<br>NAME (Type)<br>William D. Boyd M. D.   | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial                                     | 23b. DATE<br>Feb. 8, 1969  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Sacred Heart Cemetery                                   | 23d. LOCATION (City or Town)<br>Bushwood, St. Mary's, Maryland                             | (County)  | (State)   |   |
| 24. FUNERAL DIRECTOR<br>W. Clarke Mattingley   | ADDRESS<br>Leonardtown, Maryland   | 25a. REC'D. BY REGISTRAR<br>FEB 11 1969  | 25b. REGISTRAR'S SIGNATURE<br><i>W. Clarke Mattingley</i>                                       |  |   |   |   |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02940

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02935

|   |                  |   |   |   |   |  |   |                    |  |                          |         |
|---|------------------|---|---|---|---|--|---|--------------------|--|--------------------------|---------|
| 1. DECEASED-NAME<br>(Type or Print)   |                  |   | First<br>CHARLES  | Middle<br>GOTTFRED  | Last<br>ROBINSON                              | 2a. DATE KNOWN<br>OF ESTI.<br>DEATH MATED<br><input checked="" type="checkbox"/>   | Month<br>FEB.   | Day<br>11          | Year<br>1969   | 2b. HOUR<br>7.45P        |         |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE | S. DATE OF BIRTH<br>6/6/1909  | 6. AGE (in years<br>lost birthday)<br>59  | YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS             | IF UNDER 24 HRS.<br>HOURS<br>MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month<br>FEB.                 |                    |  |                          |         |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>BALTIMORE   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>ST. MARYS  |   |                    |  | 2d. HOUR<br>7.45P        |         |
| 10. CITY OR TOWN OF DEATH<br>PATUXENT RIVER   |                  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>USN STATION HOSPITAL |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>RETIRED  |   |                    | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>PLUMBING           |                          |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND  |                  | 13b. COUNTY<br>ST. MARYS  |   | 13c. CITY OR TOWN<br>CALIFORNIA   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET AND NUMBER<br>RT. 2 BOX 99                    |                    |  |                          |         |
| 14. FATHER'S NAME<br>MUNSEY   |                  |   | 15. MOTHER'S MAIDEN NAME<br>ROBINSON  |   |   | 16. ADDRESS<br>ANNIE JULIA LANG  |   |                    | Md.  |                          |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>NO   |                  |   | 16b. SOCIAL SECURITY NO.<br>212 07 0942   |   |   | 17. INFORMANT<br>MRS. MARGARET F. ROBINSON - SAME AS #13   |   |                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>insured |                          |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>464X</u> <u>Suffocation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause (b) _____<br>lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |   |   |   |   |  |   |                    |  |                          |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                  |   |   |   |   |  |   |                    |  |                          |         |
| 19a. DATE OF OPERATION  |                  |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |                    |  |                          |         |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR AM 7:10 P.M. 2-10 1969                                     |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Pt. pulled tracheotomy tub. out   |   |                    |  |                          |         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>Home |   |   | 21f. LOCATION Street or R.F.D. No.<br>Route # |  | City or Town<br>California                                | County<br>St. Mary | State<br>Md.   |                          |         |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |   |   |   |   |  |   |                    |  |                          |         |
| ACTUAL<br>SIGNATURE<br><u>W.M.D. Boyd</u>   |                  |   | 22b. DATE SIGNED<br>2/12/69   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS <a href="http://WWW.BALTIMORECOUNTY.COM">WWW.BALTIMORECOUNTY.COM</a> |   |                    |  |                          |         |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |                  | 23b. DATE<br>2-14-69  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>OLD FIELDS Cem.   |   |  | 23d. LOCATION (City or Town)<br>HUGHESVILLE, CHARLES, MD. |                    |  | (County)<br>CHARLES, MD. | (State) |
| 24. FUNERAL DIRECTOR<br>JOHN M. WELCH   |                  | ADDRESS<br>JOHN M. WELCH - LEONARDTOWN, MD.   |   |   | 25a. RECEIVED BY REGISTRAR<br>FEB 17 1969     |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>        |                    |  |                          |         |

76250

02030

Received

water sample

Two water samples taken at 45° and 70°  
from surface sample taken

Received

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Item 5 FilmG109 2/14/69 kk 02941 MARYLAND STATE DEPARTMENT OF HEALTH Items 10, 11 & 13 FilmG109 2/17/69  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 kk

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02936

|   |  |   |   |   |                                      |   |   |   |                                   |
|---|--|---|---|---|--------------------------------------|---|---|---|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)   | First<br><b>IDA</b>  | Middle<br><b>ELVA</b>   | Last<br><b>SCHWARTZ</b>   | 2a. DATE KNOWN <input type="checkbox"/> Month <b>2</b> Day <b>5</b> Year <b>1969</b> ? M                            | 2b. HOUR                             |   |   |   |                                   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>1903</b>   | 6. AGE (In years<br>last birthday)<br><b>65</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>   | IF UNDER 24 HRS.<br>DAYS<br><b>0</b> | IF UNDER 24 HRS.<br>HOURS<br><b>0</b>   | IF UNDER 24 HRS.<br>MIN.<br><b>0</b>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>FEB.</b> Day <b>7</b> Year <b>1969</b> 12.15 | 2d. HOUR                          |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b> VIRGINIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH<br><b>ST. MARYS</b>  |   |                                      |   |   |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Great Mills<br/>LEXINGTON/PARK</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Lord Calvert Motel</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)                          |                                      | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>ST. MARYS</b>  | 13c. CITY OR TOWN<br><b>Great Mills</b>   | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13e. STREET AND NUMBER<br><b>Lord Calvert Motel<br/>BOX 433/RT 11</b>   |                                      |   |   |   |                                   |
| 14. FATHER'S NAME<br>First<br><b>JOHN</b>   | Middle<br><b>BUTLER</b>  | Last  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>ANNIE</b>   | Middle  | Last<br><b>UNKNOWN</b>               |   |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  | 16c. INFORMANT  | ADDRESS<br><b>MRS. KENNETH THOMPSON 790 FAIRVIEW AVE.</b>                                       |   |                                      |   |   |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>571.9</b><br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   |                                      |   | ANNEAPOLIS, MD APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 YRS.</b> |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |                                      |   |   |   |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |   |   |                                      | 20. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |   |                                   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |   |                                      |   |   |   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)   | 21f. LOCATION Street or R.F.D. No. _____<br>City or Town _____<br>County _____<br>State _____   |   |                                      |   |   |   |                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |   |                                      |   |   |   |                                   |
| ACTUAL SIGNATURE <br>EXAMINER'S NAME (Type) <b>W.M.D. BOYD, M.D.</b>   |  |   |   |   |                                      |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D.                         | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                               | 22b. DATE SIGNED<br><b>2/7/69</b> |
| EXAMINER'S NAME (Type)  |  |   |   |   |                                      |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                     | ADDRESS (Street, city, town, or county)<br><b>LEONARDTOWN, MD.</b>                |                                   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>CREMATION</b>  | 23b. DATE<br><b>2/8/1969</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>LEE'S CREMATORIAL</b>  | 23d. LOCATION (City or Town)<br><b>WASHINGTON, D.C.</b>   | (County) _____  | (State) _____                        |   |   |   |                                   |
| 24. FUNERAL DIRECTOR<br><br><b>JOHN M. WELCH - LEONARDTOWN, MD.</b>  | ADDRESS  |   | 25a. REC'D BY REGISTRAR<br><b>2/11/1969</b>   | 25b. REGISTRAR'S SIGNATURE<br> |                                      |   |   |   |                                   |



FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02937

|  |                              |  |   |   |  |   |   |                                      |
|--|------------------------------|--|---|---|--|---|---|--------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)  |                              | First  | Middle  | Lost  | 2a. DATE KNOWN <input type="checkbox"/> Month  | Doy   | Year  | 2b. HOUR                             |
|  |                              | RAYMOND JAMES WALKER SR.   |   |   | OF ESTI.<br>DEATH MATED <input checked="" type="checkbox"/>                                | FEB. 9  | 1969  | 11.00                                |
| 3. SEX   | 4. RACE                      | S. DATE OF BIRTH   | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS   | IF UNDER 24 HRS.<br>DAYS   | HOURS   | MIN.  | 2d. HOUR                             |
| MALE   | WHITE                        | 2/22/1903  | 65 YRS.   |   |  |   |   | A.M.                                 |
| 7a. BIRTHPLACE (State or foreign<br>country)   | 7b. CITIZEN OF WHAT COUNTRY? | 8.   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH  |  |   |   |                                      |
| PENNA.   | USA                          |  |   | ST. MARYS   |  |   |   | Md.                                  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)  |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |
| POTOMAC RIVER  |                              |  |   |   | RETIRED SIGN PAINTER   |   |   |                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |                              | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                                      |   |                                      |
| WASHINGTON, D.C.   |                              |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 1265 MONROE ST N.E.   |   |                                      |
| 14. FATHER'S NAME  |                              | First  | Middle  | Lost  | 15. MOTHER'S MAIDEN NAME   | First   | Middle  | Lost                                 |
|  |                              | PATRICK  |   | WALKER  | MARIA  |   | HANOPHY   |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  | 677 N. MAIN ST.   |   |                                      |
| NO   |                              | XXXXXX   |   | 117 14 9963A  |  | RAYMOND J. WALKER JR. MEADEVILLE, PA.                       |   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HYPOTHERMIA   |                              |  |   |   |  |   |   |                                      |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost. (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                              |  |   |   |  |   |   |                                      |
| APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>15 MIN.   |                              |  |   |   |  |   |   |                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                              |  |   |   |  |   |   |                                      |
| 19a. MEDICAL CERTIFICATION   |                              | 19b. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |  |   | 20. AUTOPSY?  |                                      |
|  |                              |  |   |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.                                |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |   |                                      |
| 11.00 A.M. P. 2/9 1969   |                              |  |   | BOAT RAN AGROUND IN STORM   |  |   |   |                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/>   |                              | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office, building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  | County  | State                                |
|  |                              | POTOMAC RIVER  |   |   |  | MOUTH OF YEOCOMICO RIVER                                    | ST. MARYS   | MD.                                  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |  |   |   |  |   |   |                                      |
| ACTUAL<br>SIGNATURE  |                              | <i>Alfred Boyd</i>   |   | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>             |   |                                      |
| EXAMINER'S<br>NAME (Type)  |                              | WM. D. BOYD M.D.   |   |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>         | 22b. DATE SIGNED  |                                      |
|  |                              |  |   |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | 2/11/69   |                                      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORIUM  |  |   | 23d. LOCATION (City or Town) (County) (State)                       |                                      |
| BURIAL   |                              | 2.17.69  |   | Calvary Cemetery  |  |   | Mavfield Penna.   |                                      |
| 24. FUNERAL DIRECTOR   |                              | ADDRESS  |   | 25a. RECD. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                  |   |                                      |
| JOHN M. WELCH  |                              | LEONARDTOWN, MD.   |   | FEB 14 1969   |  | <i>John M. Welch</i>  |   |                                      |
| VR A15ME (5)<br>10M REV. 1/68  |                              |  |   |   |  |   |   |                                      |

